

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS3522AGC</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/18/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>SPRUCE OAK RESIDENTIAL CARE FACILITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4618 SPRUCE OAK NORTH LAS VEGAS, NV 89031</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments  The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.  This Statement of Deficiencies was generated as a result of a complaint investigation at your facility on 3-18-09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.  The facility is licensed for 6 Residential Facility for Group beds for elderly and disabled persons, Category 2 residents.  Complaint #21246 was substantiated. See Tag Y9999.  The following deficiencies were identified:	Y 000		
Y9999	Final Observations  NRS 449.700(1) Every medical facility, facility for the dependent and home for individual residential care must provide the services necessary to treat properly a patient in a particular case or must be able to arrange the transfer of the patient to another facility or home which can provide that care.  Based on interview and review of the events, the facility failed to ensure transfer of Resident #1 to another facility which was able to provide appropriate care.  Findings include: The incident that triggered this complaint	Y9999		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y9999	Continued From page 1  occurred on January 19, 2009, when the resident was found outside the home wandering. The police returned him to Spruce Oak and that evening he again made an effort to leave the home through the garage and was found under a car. Spruce Oak called the police and the resident was taken to Centennial Hills hospital for evaluation and he was subsequently sent to Harmon Medical and Rehabilitation Hospital At the time he was admitted to the hospital the record shows that the patient has a history of dementia. Harmon Hospital transfered Resident #1 back to Spruce Oak and the facility then transfered the resident to an unlicensed facility (Angel of Red Oak). During interview the administrator of Spruce Oak admitted that she knew little about Angel of Red Oak and did not look at any licenses that they might have. The resident was subsequently transferred from Angel of Red Oak to Luxury Care Alzheimer ' s Group Home. Severity: 2 Scope: 1	Y9999			

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